

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 15 1960

INDEXED

60-027169
3960 STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY JACKSON b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY Length of stay in 1b 5 days c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION LAKEVIEW HOSPITAL Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON c. CITY OR TOWN INDEPENDENCE Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) 9514 East 17th St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>											
3. NAME OF DECEASED First MARY Middle LOUISA Last TALLY				4. DATE OF DEATH Month AUGUST Day 1 Year 1960											
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 5-26-1889		9. AGE (last birthday) 71		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC				11. BIRTHPLACE (City and state or country) GUTHRIE CO., IOWA				12. CITIZEN OF WHAT COUNTRY U.S.A.			
13a. FATHER'S NAME JAMES A. TRENT				13b. MOTHER'S MAIDEN NAME MARY ELLEN COLCLAIZER				14. NAME OF HUSBAND OR WIFE JAMES O. TALLY							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. NONE				17. INFORMANT JAMES O. TALLY, 9514 E. 17th St., Indep., Mo.				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory & Cardiac Failure</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Hypertensive Pneumonia</i> DUE TO (c) <i>Coronary Arteriosclerosis</i>										INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)										PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)											
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____															
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				20f. CITY, TOWN, OR LOCATION				COUNTY		STATE			
21. I attended the deceased from <i>1945</i> Aug 1 1960 and last saw her <i>Aug 1 1960</i> alive on															
Death occurred at <i>Lakeview Hospital</i> on the date stated above, and to the best of my knowledge from the causes stated.															
22a. SIGNATURE <i>G. C. Carson</i>				(Degree or title) DO				22b. ADDRESS <i>4949 S. Maple Parkway</i>				22c. DATE SIGNED 8/1/60			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 8-3-60		23c. NAME OF CEMETERY OR CREMATORY MT. WASHINGTON CEMETERY				23d. LOCATION (City, town, or county) KANSAS CITY 22, MISSOURI							
24. FUNERAL DIRECTOR GEO. C. CARSON & SONS FUNERAL HOME				ADDRESS				25. DATE RECD. BY LOCAL REG. 8-1-60				26. REGISTRAR'S SIGNATURE <i>H. L. Dwyer, M.D.</i>			

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Kenneth S. Patton

Licensed Embalmer No. 4697

P. O. Address

Indigo M.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.